12.a. Prescribed drugs. (continued)

(3) The dispensed quantity of a prescribed drug must not exceed a three-month supply.

(4) An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing. No additional dispensing fee shall be paid until that quantity is used by the recipient.

(5) Except as provided in item (6), coverage of the dispensing fee for a particular pharmacy or dispensing physician for a maintenance drug for a recipient is limited to one fee per 30-day supply.

(6) More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if:

(a) the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription; or

(b) the drug is clozapine.

(7) A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes.

(8) Unless the practitioner has written in his or her own handwriting "Dispense as Written-Brand Necessary" or "DAW-Brand Necessary" on the prescription, generic drugs must be dispensed to recipients if:

(a) the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA; and

12.a. Prescribed drugs. (continued)

(b) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed.

(9) Over the counter medications must be dispensed in the manufacturer's unopened package, except that Sorbitol may be repackaged.

(10) The following limits apply to drugs dispensed under unit dose packaging:

(a) Dispensing fees for drugs dispensed in unit dose packaging shall not be paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees.

(b) Only one dispensing fee per calendar month will be paid for each maintenance drug, regardless of the type of unit dose system used or the number of times during the month the pharmacist dispenses the drug.

(c) An additional dispensing fee per prescription shall be paid to pharmacists using an in-pharmacy packaged unit dose system (except for over-the-counter [OTC] medications) approved by the Board of Pharmacy for the return of drugs when dispensing to recipients in a long-term care facility if:

(i) the pharmacy is registered with the Department by filing an addendum to the provider agreement;

(ii) a minimum 30-day supply of the drug is dispensed, although a lesser quantity may be dispensed for an acute course of medication therapy for a specified time period;

12.a. Prescribed drugs. (continued)

(iii) the national drug code from the drug stock container used to fill the unit dose package is identified to the Department;

(iv) the unit dose package containing the drug meets the packaging standards set forth in Minnesota Statutes that govern the return of unused drugs to the pharmacy for reuse and documentation that unit dose packaging meets permeability standards of the Board of Pharmacy; and

(v) the pharmacy provider credits the Department for the actual acquisition cost of all unused drugs that are eligible for return and reuse.

(11) Delivery charges for a drug are not covered.

Drug Formulary:

All drugs and compounded prescriptions made by a manufacturer that are subject to a rebate agreement with HCFA are included in the drug formulary, with the following two limitations to coverage:

(1) The following drugs require prior authorization:
- (a) Alglucerase (Ceredase)
- (b) Agents used to promote smoking cessation (includes patches, nasal sprays, gum, inhalers)
- (c) Botulinum Toxin Type A (Botox)
- (d) Demeclocycline (Declomycin)
- (e) Epoetin Alfa/Erythropoietion/EPO (Epogen and Procrit)
- (f) Filgrastim/G-CSF (Neupogen)
- (g) Granisetron (Kytril): for > 4 consecutive weeks continuous treatment
- (h) Interferon Alfa-n3 (Alferon N)
- (i) Interferon Gamma-1b (Actimmune)
- (j) Lansoprazole (Prevacid): for > 8 consecutive weeks continuous treatment
- (k) Omeprazole (Prilosec): for > 8 consecutive weeks continuous treatment
- (l) Ondansetron (Zofran): for > 4 consecutive weeks continuous treatment
- (m) Sargramostim/GM-CSF (Leukine and Prokine)
- (n) Viagra (Sildenafil)

12.a. Prescribed drugs. (continued)

(2) The following categories of drugs subject to restriction under §1927(d)(2) are *not covered*:

(a) Agents when used for anorexia or weight gain, except that medically necessary anorectics are covered for recipients previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese.
(b) Agents when used to promote fertility.
(c) Agents when used for hair growth.
(d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
(e) Drugs described in §1703(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of 21 CFR §310.6(b)(1) (DESI drugs)).

Other categories of drugs listed under §1927(d)(2) are *covered with limitations*.

12.b. Dentures.

- Purchase or replacement of dentures is limited to one time every five years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified if a client is missing teeth necessary to fit or anchor the dentures.

- Replacement of dentures less than five years old requires prior authorization.

- The payment rate for dentures includes instruction for the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

12.c. Prosthetic devices.

- Prosthetic or orthotic devices means replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or real function or to support a weak or deformed part of the body.

- Prosthetic or orthotic devices are eligible for payment with the following limitation:

  - Ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedic or physiatrics, or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

- The following prosthetic or orthotic devices and repairs are not eligible for payment:

  1) A device for which Medicare has denied the claim as not medically necessary;
  2) A device that is not medically necessary for the recipient;
  3) A device, other than a hearing aid, that is provided to a recipient who is an outpatient or resident of a long-term care facility and this is billed directly to medical assistance except as in item 7.c., Medical Supplies, Equipment and Appliances;
  4) Repair of a rented device;
  5) Repair of a device if the repair is covered by warranty;
  6) Routine, periodic service of a recipient's device owned by a long-term care facility;
  7) A device that has as a purpose to serve as a convenience to a person caring for the recipient;
  8) A device that is not received by the recipient; ~~and~~
  9) A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health; and
  10) A device not supplied by a medical supplier.

12.d. Eyeglasses:

- Payment for eyeglasses is limited to one pair of eyeglasses or one replacement of each lens in the eyeglasses in a 24-month period. Eyeglasses or a replacement of a lens in the eyeglasses in excess of this limit requires prior authorization.

- Eyeglasses or a change of eyeglasses must be shown to be medically necessary by a complete vision examination.

- The following vision care services are not eligible for payment:

  1) services provided for cosmetic reasons;
  2) dispensing services related to non-covered services;
  3) fashion tints that do not absorb ultraviolet or infrared wave lengths;
  4) protective coating for plastic lenses;
  5) edge and antireflective coating of lenses;
  6) industrial or sport eyeglasses unless they are the recipient's only pair and are necessary for vision correction;
  7) replacement of the lenses or frames if the replacement is not medically necessary;
  8) oversized lenses;
  9) invisible or progressive bifocals;
  10) a vision care service for which a required prior authorization was not obtained;
  11) replacement of lenses or frames due to the provider's error in prescribing, frame selection, or measurement;
  12) services or materials that are determined to be experimental or non-clinically proven by prevailing community standards or customary practice.

- Ophthalmic materials are purchased on a volume basis through competitive bidding.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

- See Items 13.a. through 13.d.

13.a. Diagnostic services:

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.b. Screening services:

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.